STANDARDIZED QUESTIONARIES ON RESPIRATORY SYMPTOMS*

In recent years various groups of investigators have studied the epidemiology of chronic respiratory disease both in industry and in the general population in Great Britain. In most of these surveys questionaries, completed by interviewers, have been used to establish the prevalence of common respiratory symptoms, in particular those associated with chronic bronchitis.

These symptoms vary greatly in severity—for example, from an occasional dry cough to a profuse productive cough persisting throughout the year. If the results of surveys in different populations are to be compared (and such comparisons are important aetiologically), certain levels or grades of severity of symptoms must be defined, and the questions standardized so that the same subjects are likely to be classified in the same way by independent observers. Considerable bias in estimates of the prevalence of symptoms may arise without such standardization (Cochrane *et al.*, 1951; Fletcher and Oldham, 1959). In recent years a more or less standard questionary has been adopted by most investigators in this field, and it has been shown (Fairbairn *et al.*, 1959; Higgins *et al.*, 1959) that, with appropriate care, systematic errors in diagnosis may be kept small.

In the summer of 1959 a subcommittee† of the Medical Research Council's Committee on the Aetiology of Chronic Bronchitis, all of whose members had had considerable experience in the use of respiratory questionaries in field work, met to formulate a standard questionary for future use in such studies. Two questionaries have been agreed upon: a short one with only those questions which are essential in order to estimate the prevalence of chronic bronchitis; and a longer one with a number of other questions of less certain value. Both questionaries contain questions on smoking, for this habit has such a profound effect on the prevalence of bronchitis that standardization for its influence is essential. The short questionary provides for a brief occupational history, the longer one for a full occupational and residential history. Space is provided in both questionaries for further questions which may be required in special circumstances, for recording sputum volume, for the results of ventilatory function tests, and for other clinical and radiological findings. Instructions for the use of the questionaries and suggestions for coding the replies have also been agreed upon.

The short questionary seldom takes more than five minutes to complete. The long one usually takes 10 minutes, and the full residential and occupational history, according to its complexity, takes another 5 to 15 minutes.

These questionaries and instructions have been printed and made available with the agreement of the Medical Research Council's Committee on the Aetiology of Chronic Bronchitis, and copies may be obtained from Dr. C. M. Fletcher, Department of Medicine, Postgraduate Medical School, Ducane Road, London W.12.

*A statement prepared for, and approved by, the Medical Research Council's Committee on the Aetiology of Chronic Bronchitis.

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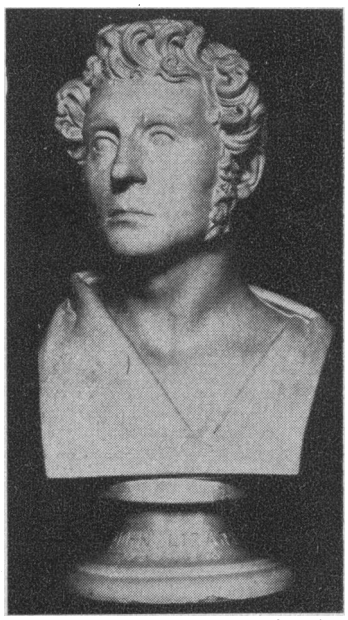
Nova et Vetera

JOHN LIZARS

CENTENARY OF A FORGOTTEN PIONEER OF THE SURGERY OF TRIGEMINAL NEURALGIA*

To his contemporaries Lizars was not a whit less in stature than any one of the brilliant company of surgeons of Edinburgh of his time, yet posterity has never conferred upon him the ageless esteem which Liston and James Syme have received. Among Lizars's numerous contributions to surgery, the account he gave of the first neurotomy of one of the deeper branches of the trigeminus for the relief of neuralgia is of particular interest to the neurologist.

In a well-documented paper published in the *Edinburgh Medical and Surgical Journal* in 1821[1] he describes a patient with trigeminal neuralgia which he relieved in December, 1819, by dividing the mental nerve at the point of its emergence from the mental foramen. The patient remained free from symptoms for twelve months, after which the "same torturing pains returned." As the patient had "no faith in anything but the knife," Lizars again divided the nerve at the mental foramen. However, neither this operation nor cautery, which was applied later, relieved the pain. The patient was prevailed upon to allow the application of moxa, which was equally ineffective. Accordingly on March 15, 1821, Lizars, after making a perpendicular incision inside the mouth close to the coronoid process, introduced a gum lancet between the bone and internal pterygoid muscle. "When the lancet reached the seat of the inferior maxillary nerve, the pain he experienced was intolerable; and it was with difficulty he could sit till I cut the nerve completely. From this moment there was a sudden satisfactory termination to all his suffering." Writing in August, 1821, Lizars says, "The other day I saw him toiling in the field with apparently great enjoyment of life."



Photograph of the bust of John Lizars in the Royal College of Surgeons, Edinburgh.

John Lizars was born in 1787 and was the son of Daniel Lizars, an artist in Edinburgh "considered to be very eminent in his profession." On leaving the High School he

*An abridged communication made to the Osler Club, London.